A Community-Based Care Model for the Elderly

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The objective of this qualitative study is to use participatory action research in a community in Northeastern Thailand to find an appropriate model for caring for elderly residents. Research participants included 140 seniors, 11 community leaders, 20 relatives of the seniors, 4 professional nurses at the health center, and 5 local administrators. The study collected data via a daily capability survey of selected seniors using the Barthel ADL index, participant observations, in-depth interviews, and focus group discussions. Data were analyzed quantitatively and qualitatively. Quantitative analysis was based on statistical averages while content analysis was performed qualitatively. For the purposes of this study, elders were grouped into four categories: self-dependent, semi self-dependent, non self-dependent, and without caring groups.

Elders' needs are varied, including health support services and care when sick, financial stability and a living income, the ability to stay with family including children and grandchildren, and community acceptance and association.

The proposed community-based care model for elderly care in the community is a partnership model formulated through brainstorming with involved parties. It offers to support seniors to stay with family and to sustain a care system for longer periods in case of the non self-dependent elderly group. It would establish senior associations, organize financial cooperatives, and initiate welfare for senior residents. Furthermore, it proposes that all seniors should receive a pension. This elder care model relies on horizontal relationships based on community resources and capability.

Keywords: Elderly care system, Community-based care, semi self-dependence
Introduction

Thailand is an aging society. This will create potentially negative effects as the societal burden for caring for the elderly grows. Kamnuansilps et al. (2004) projected that the number of dependent elders would double by 2025. Thailand will face many difficulties as it becomes an aging society.

Traditionally, Thailand was an agricultural/rural society reliant on extended family relationships with Buddhism at its root. Younger Thais respected the elderly. With modernization, Thailand is evolving into an urban society with government officials replacing extended family support. Traditions, norms, and beliefs are changing.

Numerous studies have been conducted on the elderly Thai population, including their health, their care and welfare, and the burden of elderly care from the family to national levels. Sritanyarat and Aroonsang (1996) show that many Thai elders had conditions that made them dependent on other family members. These conditions are expected to increase as the number of elderly grows (Jitapunkul, 2002a). It will affect not only family care expenses, but also national budgets. As a result, the community, society, and organizations such as local administration will come to play a key role in enhancing elderly care (Jitapunkul, 2002b; Sriipanich, 2009).

The Thai government, aware of this situation, is preparing for this change in population structure. A long-term national plan for elderly persons from 1982-2001 has been followed by a modified plan for 2002-21 (National Committee for the Elderly, 2002). The second plan, in particular, focuses on providing elderly care with community involvement. It starts from individual self-caring and builds toward family, community, and national support (Siriphanich, 2009; National Committee for the Elderly, 2002).

Even with a government policy to develop the community and social structures to improve the quality of life of the elderly, the support and care of family members remains important. However, there are limits to the care families are able to provide. Given this, this paper proposes a community-based approach to support self-caring with limited assistance from the national care service system. State officials, once service providers, now play a supporting role as a human resource and in the provision of knowledge. On the other hand, the neighborhood, community leaders, and local associations will play significant roles in taking care of the elderly. Developing the requisite skills and knowledge within the community is critical.
Methodology
Design and Key Informants

Through participatory action research, this study aims to develop a community-based care model for the provision of elderly care in Thailand. A single community in Khon Kaen Province, Thailand is used as the basis for the study. The research was conducted over a period of 12 months. Each elderly participant’s physical capabilities were assessed using a modified version of the Barthel Activities of Daily Living (ADL) Index (Jitapunkul, 2001). The researcher conducted in-depth interviews with both the elderly and other residents as well as observed the elder’s lifestyle in order to select participants and key informants.

The selected volunteer participants included 140 elders (key informants), 20 family members of the elders, 11 community leaders, 4 health center officials, and 5 local administrators. The elders were classified into four groups: self-dependent, semi self-dependent, non self-dependent, and poor without a care provider. The self-dependent group (73.6%) included 103 elders with 48 males and 55 females, ages 60-81. Two were single, 74 married, and 27 divorced. They all had a primary school education. The semi self-dependent group (19.3%) included 27 elders with 8 males and 19 females, ages 60-90. Eleven were married and 16 divorced. Nineteen had a primary school education and 18 had no formal education. The non self-dependent group (6.4%) included nine elders, three males and six females, ages 60-103. Four had a primary school education and five no formal education. The poor elderly without a care provider group was a single individual: a 70-year old divorced woman with a primary school education. All of the elderly participants were Buddhist.

The majority (n=15, 75%) of the 20 family members were daughters who received their income from agriculture (n=12; 60%), were educated through 9th grade (n=13; 65%), and averaged 32 years old. All family member participants lived with their respective elders.

The 11 community leaders (average age of 52) included one village chief, two assistant village chiefs, one village patrolman, two village administrators, and five village committee members. Four of the community leaders had a primary school education and the other seven had a secondary school education.

Four of the five local health center nurses, who provided care for the elders, held a baccalaureate degree in nursing. The other nurse had a master’s degree in community healthcare. The nurses, on average, were 46 years of age and had 11 years of work experience.

Of the ten healthcare volunteers (average age of 53), eight were
female, seven had primary school education, and seven were farmers. The leader of the volunteers had 21 years of experience as a volunteer.

The five local government officials had an average age of 54 years and consisted of one chief local administrator, two deputy chiefs, one assistant deputy chief, and one director of the local Health and Environmental Department. All of the government officials were college-educated males.

The community was selected because the primary investigator (PI), as an instructor, brought nursing students there for 15 years. Thus, she was trusted and respected by the members of the community, community leaders, and local government officials. As a result, the PI was able to easily engage and work with all study participants.

Human Rights Protection

Since this research may involve sensitive topics including illness conditions and conflict within families, it may cause emotional discomfort among participants. To protect participants from physical and mental harm, the research follows the principle of respect for human dignity and the principle of justice and conduct with accuracy (Denzin and Lincoln, 1998, 2000). To do this, the researcher obtained all of the following: clearance from the ethical committee on human research at Khon Kaen University, a permit to conduct research within the local tambon from the community leader and head of the health center, and a signed or verbal agreement from every participant volunteering in the research. In addition, the research was designed to yield accurate, reliable, and verifiable data.

Procedure

The research consisted of two phases. Phase I involved data gathering using interviews, participatory observations, focus group discussions, and a review of documents regarding the needs of the elderly. The informants were elders and their family members, healthcare volunteers, professional nurses, community leaders and local government officials. Phase II involved development of an appropriate community healthcare model for the elderly, which represented the ideas, procedures, constraints, and roles of the participants involved in data generation during Phase I. Participants in Phase II included purposively selected individuals from each of the informant groups from Phase I.

Phase 1: data gathering regarding the needs of the elderly. The first phase studied the current elderly care system in the selected com-
munity. During the first community visit, the researcher contacted the community leader, the head of the healthcare volunteers, and officials from the village health center to inform them of the research objectives and related details. The researcher also asked them to participate in the research and data collection process.

The method and tools to collect data included a basic survey and evaluation of elders’ daily activities, in-depth interviews, participant observations, and focus group discussions. The survey used the Barthel ADL index with an evaluation of daily capabilities such as self-cleansing, dressing, eating, excreting, standing, moving up and down, and communicating. Based on the evaluation, the elders were divided into three groups: self-dependent, semi self-dependent, and non self-dependent. In-depth interviews focused on the meaning of being elderly residents and the problems or needs of each group. The interview asked three types of questions: descriptive, comparative, and structured. Each interview lasted about 1 to 1 1/2 hours. Participant observations provided data on the actual conditions of the elderly. The researcher also visited and observed elderly households during healthcare provider visits. Focus group discussions were conducted with directed topics to exchange opinions among participants (Morse and Field, 2002).

Phase 2: development of a community-based care model for the elderly. The second phase developed and proposed a community-based care model for each elderly group. This phase consisted of two stages: (a) data verification from primary informants and members of each focus group and (b) brainstorming with select study participants on the development of a relevant community model for elderly care. During the data verification stage, the PI validated her interpretation of the data, gathered during Phase I, with the participants. The elders examined the accuracy of their respective demographic data, physical capabilities, and content of the in-depth interview. Members of each focus group were given the opportunity to review a summary of the interpretation of the data obtained during their respective discussions. The family members’ focus group examined data related to the roles family members assumed in care of the elders, the physical condition of the elders, and the family needs related to community and local government services. The healthcare volunteers and community leaders’ focus group examined data related to community resources and types of community activities/support that should be provided to elders and their families, while the nurses and local government administrators’ focus group examined data on the activities and roles of the individual participants’ organizations in delivery of care to the elders.
Brainstorming, the second stage of Phase II, involved input from 59 purposively selected study participants who met who met to develop a community model for care of the elderly, based on the data gathered and analyzed during Phase I. Ten participants were selected from the elders assessed to be independent and six were selected from the elders assessed to be semi-dependent. Five family members of the elders assessed to be independent, semi-dependent, or dependent (for a total of 15) were selected, as well as 10 healthcare volunteers, 7 community leaders, 5 registered professional nurses, and 6 local administrators. All of these participants met together with the PI for a brainstorming session.

The brainstorming session began with the PI presenting a 30-minute summary of the analysis of the data gathered during Phase I. The participants then were divided into two groups. One group consisted of elders, family members, healthcare volunteers, and community leaders. The second group included the professional registered nurses and local government officials. A research assistant, familiar with both the study and the techniques of running a brainstorming group, moderated each session. The PI went back and forth between the two groups to make certain the purpose of the brainstorming sessions was being accomplished. Each of the two sessions lasted approximately two hours. At the conclusion of the two sessions, a representative from each session presented, to the participants of both sessions, their proposed model for community care of the elderly. The two presentations lasted about one hour.

Data Analysis

This research used statistical frequency and percentage values for analyzing the quantitative data. More importantly, the qualitative data was analyzed through a variety of methods. Data organization was used to identify and categorize topics from the collected data. Thematic analysis was applied to classify data by themes in order to identify an appropriate model for each elderly group. Time-line analysis was conducted to associate events and timing for each group sample, providing a better understanding of their daily life, needs, and the associated care system. Lastly, comparative analysis displayed similarity and distinguished differences based on data characteristics to identify its relationship (Podhisita, 2004). The researcher used this last analysis to reason relationships between key informants.

For the qualitative data, a three-way data test was used to confirm the data creditability from the various sources and gathering techniques. The familiarity between sources and researcher was then proven for its reliability, to assure data usage and to reflect actual conditions. Finally, analyzed data and findings were rechecked with data sources and other
expertise to debrief knowledge for this research (Jilawatkul, 2003; Podhisita, 2004).

Results

Care System Targets (Elderly Groups)

Meaning of elderly population in community’s view. The 2006 Act of Elderly Population defines senior citizens as a Thai national age 60 years or more. Less precisely, at the community level, elders are accorded respect as older residents. They are referred to as “poryai” for men and “maeyai” for women. These titles have equivalent roles as grandfather and grandmother. They usually stay home to raise grandchildren so that their son and daughter can work outside the home. Furthermore, seniors are characterized as those of old age with grey hair, wrinkles, and slow movements. They are less self-dependent. This community definition is based on physical conditions.

- The more aged you are, the older you get. Your eyesight becomes unclear. It is not easy to see. (Female-71)
- When you are old, your body is no longer strong. Your hands and legs are wrinkled. (Male-72)
- You can’t go anywhere. You must stay at home, taking care of grandchildren. You go out just to attend temple ceremonies. (Female-65)

Elderly daily life from the elder’s viewpoint.

Group 1: self-dependent elderly residents. Elders who are heads of family. They are a main source of income, helping support the family. Seniors in this category, both men and women, usually do their own rice farming or are hired on other farms to earn family income. After rice farming season, they may grow garden vegetables or catch freshwater fish and shrimp to eat or sell. They may reside with the whole family, with grandchildren, or alone.

- When I finish my rice farm, I will be hired by others. They pay on their knowledge and faith in Christianity, THB 150-200 a day, depending on the owner’s available time. I am strong. I still can catch some frogs. The young don’t want to grow rice. They think it is difficult. Working in a factory is more convenient. (Female-73)
- I used to be secure with THB 5,000 a month. I was fired because of old age. Then, I returned to grow rice. (Male-70)
- I get hired on rice farm for THB 150-200 a day. Some days, I don’t have money to spend. Some days, I do. I stay alone, so I spend efficiently. I don’t buy unnecessary things. (Female-62)
Elders who are official and unofficial community leaders. When these seniors retired, they volunteered in the community, assuming roles as official and unofficial community leaders. For example, some became chairpersons of the healthcare volunteers to monitor the provision of healthcare services to village residents. Moreover, some are well respected and lead the community in religious activities.

- I have been a healthcare volunteer for 28 years. I am also a head of a housewife association. As a volunteer, I visit patients, talk with them, measure baby weight, and meet with doctors at the healthcare unit. (Female-72)
- I have gone to the temple every day for the 20 past years. My brother brings me there. During the religious ceremony, I am a key man because of my acquaintance with the monks. (Male-76)

Elders who raise grandchildren. They are the primary caregivers raising their pre-school and school-aged grandchildren. The children’s parents work outside the community, such as in Bangkok, and leave their children with these elders. The seniors provide food, care for sickness, teach, and monitor school progress. They are willing to do these duties because they love their grandchildren. In addition, the parents cannot go to work to earn income for the whole family unless these elders take care of their grandchildren.

- I help raise my grandchildren so their parents can go to work. In Bangkok, the room is so small and there is nobody to stay with them. Their parents might need to work overtime to earn extra pay. Each month, their parents send me THB 5,000 for living expenses. (Female-61)

Elders who provide healthcare. They take care of other family members, including when the family members are sick. This includes spouses taking care of each other when the other is sick. They provide support, monitor conditions, and help in daily activities.

- I have taken care of my mentally-ill husband for five years. He cannot totally help himself and has difficulty remembering. He cannot walk and talk well. I have to help him with everything including food, medicine, doctor’s appointments, going to the bathroom, taking a bath, and cleaning. (Female-68)
- The doctor told me that my wife had cancer last year. She lost her willingness to live and didn’t want to receive treatment. I help her with everything, including seeking herbal medicine. I have looked after her from then until she passed away last month. (Male-65)
Elders who are career role models. Some elders provide moral support to their children and grandchildren. After they stop working and their children take over their work, they stay home to care for their grandchildren.

- I have sold silk for 30 years so that I had a car, house, and rice farm. Two years ago, my son asked me to stop and let his wife do instead. Now, I stay home and go to the temple to meditate and make good merit every Buddhist day. (Female-63)

Group 2: semi self-dependent elderly residents. Some elders, as they age, encounter health problems that limit their ability to care for themselves, including chronic conditions such as diabetes, high blood pressure, and other symptoms related to muscles and bones. Their conditions reduce their ability to carry out many daily activities and they often cannot provide healthcare for themselves. Consequently, some elders rely on their offspring to help with daily activities and healthcare.

- I stay with my son and nephew. I have had high blood pressure for a year. I take medicine to reduce stress. I am so sad due to the death of my husband a year ago. Then, my daughter and daughter-in-laws also passed away. My son takes care of me and brings me to the hospital. I, in turn, help take care of his house as much as possible. (Female-76)

Group 3: non self-dependent elderly residents.

Much older seniors who cannot take care of themselves. Because of medical advances, better lifestyle behaviors, and better self-care practices, the Thai population is living longer than in the past. It has both positive and negative issues for elderly residents. For example, those living longer and in good health are likely to have better economic status, family matters, life quality, and happiness. On the other hand, those living longer but suffering from illness are less capable of caring for themselves and lack security. In addition, these elders require close and continued care.

- He is 103 years old. He cannot help himself or walk by himself. He has a hearing problem and doesn’t speak clearly. He also has bad eyesight. Luckily, he can eat. In the afternoon, he stays alone. His daughter goes for construction work in town. Before she left, she prepares food for him. But he cannot eat it some days because chicken eat it. Sometimes, I help take care of him by bringing some food. He has been in this condition for two years. (Neighborhood Male-40)
Elders who cannot take care of themselves due to chronic symptoms and paralysis from side effects. Some seniors have chronic symptoms such as diabetes. They cannot take care of themselves and cannot control their condition. They are likely to have other related illness. For example, it may cause serious and chronic wounds such that their legs may be amputated. It leads to handicaps and affects emotional health or mental illness. They need help bathing, excreting, eating, and taking medications. It is a tough burden on the care provider, and can disrupt their working life.

- I have to take care of my 65-year old mother who cannot help herself. She has had diabetes for 30 years. She cannot continuously control her blood sugar level. Three years ago, she wounded her right foot, which later was amputated. She cannot take it because it limits her movement. Also, my father passed away last year. She is even sadder and needs medicine for her mental condition. Some days, she speaks unclearly. Now, she cannot take care of herself. I have to watch over her in eating, excreting, and cleansing activities. It is very tough on me. I had to quit my job to take care of her. (Care Provider Female-43)

Group 4: elderly without caring group

Elders having no offspring and living in a temple. Some female seniors have no family or relatives. Perhaps they are from other villages, having married a local. After the husband dies, the in-laws no longer welcome them into the family. These female elders choose to stay in the temple as dedicated nuns. They clean rooms in the temple in exchange for food.

- I am 65 years old. I came from Mahasarakam Province to marry my late husband who passed away last year. His children welcomed me. However, after his death, they took back the house and do not want me to live there. I have no other place to live, so I became a nun and live in this temple. I clean around the temple. I think I will stay here for the rest of my life. (Nun-65)

Elders having offspring but still living alone. Some elders may have offspring but due to economic difficulties, their relatives may have left the home to work elsewhere at an early age. These elders stay home and make their own living. They wait for the children to return or for their financial support. They have to take care of themselves during normal and ill conditions.

- I am 68 years old. I have lived in this house for 3-4 years. I have been married since I was 20 and have two children, a son and a daughter. My husband is an alcoholic and gambling addict. I cannot stand that, so I took my children home. Now, my children work in Bangkok. I have not
heard from my son in three years. I am very worried about his wellbeing. My daughter is married and does not want to stay here with me. She and her husband don’t want to grow rice. She doesn’t provide financial support for me and only visits me once in awhile. So, I live alone and take care of myself. (Female-68)

Issues of Concern and the Needs for Elderly Care

To live with children and relatives. Elderly residents expect and need to spend their life with family and relatives. They hope that they can take care of themselves and are valuable to their family. They want to participate in community activities so that they can meet and communicate with other elders. When they become sick, they want their offspring to take care of them. They want to be remembered and honored by their family and relatives.

• I stay with my daughter, my son-in-law, and my grandchildren. They take care of all household expenses. When I get sick, I want them to take care of me. (Female-72)

To have stronger physical condition to go anywhere. Senior residents share healthcare concerns. When they become sick, their conditions tend to deteriorate quickly and recover slowly. Furthermore, illnesses often create serious side effects that require elders and their family to spend more for treatment. They hope to be stronger physically and better able to take care of themselves.

• I want to get better and walk again. I want to travel to Chiang Mai or Chiang Rai. (Female-65)
• I want to see and walk again, so I can go anywhere I want. (Female-70)

To earn income and have economic security. Most seniors in the community receive financial support from their children. They do not have savings. Some are still able to work in farms to earn income. Some have grandchildren, so they have to earn income for their grandchildren and themselves. Furthermore, they want to receive elderly welfare according to government policy.

• I want to help senior residents to earn some income. Some seniors are strong enough to work, but stay at home. For example, there should be a senior association for investment so that these seniors can get loans to open grocery shops. They can work and get paid. (Head of Healthcare Volunteers, Female-72)
• I want government to give state elderly welfare to all senior residents. Only a few seniors receive it in this village. Some do not deserve it because they have children that have a better living standard. Some seniors don’t even have children to take care but don’t receive this money. (Female-65)
• I want to get state elderly welfare for my daily living. (Female-63)

To participate among elderly residents. In the past, senior residents were well respected within the community. With knowledge and experience, they were considered a community resource, helping to sustain the community. Nowadays, Thai society has less respect for its elderly population due to social changes. They are left alone in the afternoon, so they feel lonely. Therefore, seniors need to gather so that they can help each other. They can visit each other when someone is sick. They can communicate or get involved in activities to entertain themselves. They want to feel beneficial to others and society.

• I want to participate with other seniors. Some stay home during the day and feel lonely. If we can meet, we will not feel that. Some seniors have children, but they don’t have time to speak with them. If we have an association, we would take care of each other when one gets sick. We can visit at home or in hospital. We can give support to each other. (Head of Healthcare Volunteers, Female-72)
• I had an idea to organize an elderly association. We have 300 members, including a chairperson and committee. We organize senior day. There are many activities and gifts for all seniors. We bring awareness among young adults to take care of their grandparents. (Village Leader, Male-60)

To be taken care of by their offspring. When elders are ill, they prefer to be taken care of by their offspring. Because they love their offspring, the elders have higher expectations of them. In Thai society, being grateful to parents and grandparents is still a very important norm.

• I want my daughter and son-in-law to come back from Bangkok and stay with me. I am not as strong as before. I have had diabetes for five years. I want them to take care of me. (Female-65)

To be visited by relatives and friends. Relationships within the community are like those of a large extended family. It is a valuable community asset with residents often taking care of neighbors and others. Elders often need help watching grandchildren and the house while they go to doctor appointments. Furthermore, relatives and neighbors can give advice for treatment and visit them in the hospital.
• When I had surgery to remove a stone, my offspring from various places came back to visit me in the hospital. I receive lots of support. This community takes good care of each other and gives lots of support. (Male-72)

To receive healthcare service at home. Elders may have health problems, with some having chronic conditions. Some seniors are paralyzed and cannot help themselves. This particular group needs special and continuous care at home from professionals such as nurses and volunteers who provide healthcare service and recovery, talk, and support.

Care System for Community’s Elderly Residents

The care system for elderly residents should integrate the roles of society and issues of culture and tradition. This consideration is a result of active participation of involved parties in the community. Its objective is to give better care toward elders so that they would be in better health; can actively participate among other senior residents; have more security in social, economic, and safety aspects; and, finally, can live with their family and relatives. The detailed activity toward caring for each elderly group is depicted in Figure 1.

![Diagram of Community Healthcare Systems]

Figure 1. Community healthcare systems

1. For the self-dependent elderly group, the care system should emphasize providing support so that they can take care of themselves as long as possible. Caring activities aim to give knowledge and change their daily behavior on healthcare and illness prevention such as eating habits, exercise, and stress management. The system should also enhance
and support elders to use and develop their capability and experience to benefit themselves, close family, relatives, and society. This can be achieved by organizing an elderly association to become involved in these activities and to create work for these capable elders.

2. For chronically ill elders who cannot help themselves, the care system should help them regain their self-caring ability. If they cannot regain their ability, the system should provide long-term care so that they can sustain their living conditions. This system would involve family and relatives, neighbors, and healthcare volunteers and nurses from the health center.

3. The system should enhance the family’s role as a main mechanism to provide care for elderly residents. Because most of the seniors need to live with their respective families, system activities should involve family participation. It should encourage their offspring to work closer to home. In addition, it creates mutual living conditions through training so that they can better care for elderly patients.

4. Community and local administration must take an active role to provide healthcare. This would create and encourage families to provide care for their grandparents, promote associations for elders in the community, and give residents financial assurance via community funds and welfare. This would strengthen the community to build self-dependence.

Discussion

This study categorizes elders in the community into four groups: self-dependent, semi self-dependent, non self-dependent, and without care. Staying with their families would give these seniors care and security during illness. Besides, most elders want to contribute to their families while their sons and daughters are away working. Seniors with good health and self-dependence play some role in their family.

Elders with High Risk Who Need Priority and Special Care

High-risk elders include the non self-dependent with paralyzing or disabling conditions, or having chronic diseases and other related symptoms. These seniors need continuous and effective care. This requires capability enhancement among public healthcare volunteers and creation of a caring and support network by relatives and neighbors. The personnel involved in these activities are community nurses from the health center, care providers, relatives, neighbors, and healthcare volunteers.

High-risk elders also include those who are single and living on their own. The activity suitable for this elderly group is a healthcare protection
system. It reinforces their economic security and creates a supporting system for those who are living alone or without relatives and cannot help themselves. This system is delivered by local residents or through unofficial care systems such as by relatives, neighbors, healthcare volunteers, elderly associations, and care systems organized by the community or local administration.

Roles and Duties of Involved Parties

1. The health center is a primary healthcare unit within the Thai public health system provided by professional nurses. They provide healthcare reinforcement, disease prevention, treatment, and rehabilitation for their respective community. This study focuses on their roles toward providing all four above aspects of healthcare for elderly residents. It needs to develop and update a database for each elderly group. It should provide special access for seniors to receive treatment at the health center. It should initiate an elderly care system in the community by a network of care providers, relatives, neighbors, and other local organizations.

2. Local administration: This study found many difficulties inhibiting elders from living and associating within their community. They have problems with their health, economic security, and lack of welfare. The local administration has a duty to equally provide welfare for all elderly resident groups according to public health regulations. It is also required to distribute pensions and to help capable seniors to earn income for themselves and their families. It supervises healthcare projects on disease prevention.

3. Community leaders, healthcare volunteers: They are key personnel taking part in a strong care system for seniors.

4. Family level: The system should create harmonious living conditions among family members of different ages, a social norm of the Thai family.

5. Community and other residents: Their role is to support the family so that elders can have a regular life in the community. They will make sure that elders who are without care from family will receive all benefits they are due. They also provide necessary help and care such as during sickness. They organize associations for senior activities and set up financial cooperatives.

Conclusion and Recommendations

Like other qualitative research, this study may have limitations as an explanatory model for other communities due to differing social and
cultural contexts. As this study is limited to a particular rural village in Northeastern Thailand, its lessons are particularly limiting for an urban community.

For future research, it is recommended that the care system for elderly residents in an urban setting should be a topic of interest since there exists a difference in social and cultural context in these areas. It is also suggested for a study on knowledge and awareness among residents toward rights of seniors according to the 2003 Act on the Rights of Seniors.

An elderly care system in the community should provide care for all groups of elders. Its activities are developed to include healthcare, economic and social support, as well as the roles and involvement of elders in the family and community. This system developed for the local level can strengthen the community to become self-dependent. This system is different from the healthcare system provided by the government. More specifically, it involves participation from senior residents, community organizations, and public officials working in a partnership model (Courtney, 1995, 1996; Leelakraiwan, 2007). Furthermore, the development process leads to capacity enhancement of community nurses. They take the primary role of healthcare provider and a managing role in the intersectional care system. They respond to the daily lifestyle needs of elderly residents. Finally, healthcare management emphasizes active participation from stakeholders in a partnership model. It uses community assets and capacity as a working basis. It also creates cooperation among networks so that the community has strengthened its elderly care system and becomes self-dependent (Siriphanich, 1986, 2009; Wasi, 2009).

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